- Prior authorization for a non-preferred agent in any category will be given only if there has been a trial of the preferred brand/generic equivalent or preferred formulation of the active ingredient, at a therapeutic dose, that resulted in a partial response with a documented intolerance.

- Prior authorization of a non-preferred isomer, pro-drug, or metabolite will be considered with a trial of a preferred parent drug of the same chemical entity, at a therapeutic dose, that resulted in a partial response with documented intolerance or a previous trial and therapy failure, at a therapeutic dose, with a preferred drug of a different chemical entity indicated to treat the submitted diagnosis. (The required trial may be overridden when documented evidence is provided that the use of these preferred agent(s) would be medically contraindicated.)

- Unless otherwise specified, the listing of a particular brand or generic name includes all legend forms of that drug. OTC drugs are not covered unless specified.

- PA criteria for non-preferred agents apply in addition to general Drug Utilization Review policy that is in effect for the entire pharmacy program, including, but not limited to; appropriate dosing, duplication of therapy, etc.

- The use of pharmaceutical samples will not be considered when evaluating the members' medical condition or prior prescription history for drugs that require prior authorization.

- Quantity limits may apply. Refer to the Limits List at: http://www.dhhr.wv.gov/bms/Pharmacy/Documents/DrugLimitationSummary.pdf

- Acronyms
  - CL - Requires clinical PA. For detailed clinical criteria, please refer to: http://www.dhhr.wv.gov/bms/Pharmacy/Pages/pac.aspx
  - NR - New drug has not been reviewed by P & T Committee
  - AP - Non-preferred and selected preferred drugs, where indicated, are subject to auto-PA criteria. See PA criteria column.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
ANTI-ALLERGENS, ORAL			
		GRASTEK (timothy grass pollen allergen extract) ORALAIR (mixed grass pollens allergen extract) RAGWITEK (short ragweed pollen allergen extract)	Full PA Criteria for this category may be found on the BMS Website: http://www.dhhr.wv.gov/bms/Pharmacy/Pages/pac.aspx
ANTIEMETICS[AP]			
	5HT3 RECEPTOR BLOCKERS		
	ondansetron ODT, solution, tablets	ANZEMET (dolasetron) granisetron GRANISOL (granisetron) ondansetron vials SANCUSO (granisetron) ZOFRAN (ondansetron) ZUPLENZ (ondansetron)	A three (3) day trial of a preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. PA is required for ondansetron when limits are exceeded.
	CANNABINOIDS		
		CESAMET (nabilone) dronabinol MARINOL (dronabinol)*	Cesamet will be authorized only for the treatment of nausea and vomiting associated with cancer chemotherapy for patients who have failed to respond adequately to three (3) day trials of conventional treatments such as promethazine or ondansetron and are eighteen (18) years of age or older. Marinol (dronabinol) will only be authorized for: 1. The treatment of anorexia associated with weight loss in patients with AIDS or cancer and unresponsive to megestrol **or** 2. The prophylaxis of chemotherapy induced nausea and vomiting unresponsive to three (3) day trials of ondansetron or promethazine for patients from eighteen (18)

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			up to sixty-five (65) years of age.
	SUBSTANCE P ANTAGONISTS		
	EMEND (aprepitant)		
	COMBINATIONS		
		AKYNZEO (netupitant/ palonosetron	
BRONCHODILATORS, BETA AGONIST[AP]			
	INHALATION SOLUTION		
	ACCUNEB (albuterol)* albuterol	BROVANA (arformoterol) levalbuterol metaproterenol PERFOROMIST (formoterol) XOPENEX (levalbuterol)	Thirty (30) day trials each of the chemically distinct preferred agents in their corresponding groups are required before a non-preferred agent in that group will be authorized unless one (1) of the exceptions on the PA form is present. *No PA is required for Accuneb for children up to five (5) years of age.
	INHALERS, LONG-ACTING		
	FORADIL (formoterol) SEREVENT (salmeterol)	ARCAPTA (indacaterol maleate) STRIVERDI RESPIMAT (olodaterol)	Thirty (30) day trials each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
	INHALERS, SHORT-ACTING		
	PROAIR HFA (albuterol) PROVENTIL HFA (albuterol)	MAXAIR (pirbuterol) VENTOLIN HFA (albuterol) XOPENEX HFA (levalbuterol)	Xopenex Inhalation Solution will be authorized for twelve (12) months for a diagnosis of asthma or COPD for patients on concurrent asthma controller therapy (either oral or inhaled) with documentation of failure on a trial of albuterol or documented intolerance of

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			albuterol, or for concurrent diagnosis of heart disease.
	ORAL		
	albuterol IR, ER terbutaline	metaproterenol VOSPIRE ER (albuterol)	
HEPATITIS C TREATMENTS[CL]			
	HARVONI (ledipasvir/sofosbuvir)* PEGASYS (pegylated interferon) PEG-INTRON (pegylated interferon) RIBASPHERE 200 mg ribavirin VIEKIRA PAK (dasabuvir/ombitasvir/ paritaprevir/ritonavir)	COPEGUS (ribavirin) INFERGEN (consensus interferon) OLYSIO (simeprevir)* REBETOL (ribavirin) RIBAPAK (ribavirin) RIBASPHERE 400 mg, 600 mg (ribavirin) ribavirin dose pack SOVALDI (sofosbuvir)* VICTRELIS (boceprevir)*	For patients starting therapy in this class, a trial of the preferred agent of a dosage form is required before a non-preferred agent of that dosage form will be authorized. *Full PA criteria may be found on the BMS Website: http://www.dhhr.wv.gov/bms/Pharmacy/Pages/pac.aspx
HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS			
	INJECTABLE		
	BYETTA (exenatide)[AP] VICTOZA (liraglutide)[AP]	BYDUREON (exenatide)* SYMLIN (pramlintide) ** TANZEUM (albiglutide) TRULICITY (dulaglutide)	A thirty (30) day trial of one (1) preferred agent with a chemical entity distinct from the requested non-preferred agent will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. All agents (preferred and non-preferred) require a previous history of a thirty (30) day trial of metformin. For concurrent insulin use, all agents will be approved in six (6) month intervals. For re-authorizations, documentation that HgBA1C levels have decreased by at least 1% or are maintained at ≤8% is required. HgBA1C levels submitted must be for the most recent thirty (30) day period. (Concurrent therapy with a bolus insulin is contraindicated.)

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			*Bydureon will not be authorized with insulin therapy of any kind. **Symlin will be authorized with a history of bolus insulin utilization in the past ninety (90) days with no gaps in insulin therapy greater than thirty (30) days.
	ORAL [AP]		
	JANUMET (sitagliptin/metformin)[AP] JANUVIA (sitagliptin) [AP] JENTADUETO (linagliptin/metformin) [AP] TRADJENTA (linagliptin) [AP]	JANUMET XR (sitagliptin/metformin)* KAZANO (alogliptin/metformin) KOMBIGLYZE XR (saxagliptin/metformin) * NESINA (alogliptin) ONGLYZA (saxagliptin) OSENI (alogliptin/pioglitazone)	Thirty (30) day trials of each chemically distinct preferred agent are required before a non-preferred agent will be approved. All agents (preferred and non-preferred) require a previous history of a thirty (30) day trial of metformin. For concurrent insulin use, all agents will be approved in six (6) month intervals. For re-authorizations, documentation that HgBA1C levels have decreased by at least 1% or are maintained at ≤8% is required. HgBA1C levels submitted must be for the most recent thirty (30) day period. *Janumet XR and Kombiglyze XR will be authorized after thirty (30) day trials of the preferred combination agents.
HYPOGLYCEMICS, SGLT2			
		FARXIGA (dapagliflozin) INVOKANA (canagliflozin) JARDIANCE (empagliflozin)	Invokana and Farxiga will be authorized for six (6) months if the following criteria are met, unless one (1) of the exceptions on the PA form is present: 1. Diagnosis of Type 2 Diabetes **and** 2. Thirty (30) day trial of

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
			metformin or metformin combination and at least one (1) other agent in the sulfonylurea class or a preferred agent from the basal insulins, TZD, DPP4, or GLP1 classes within the past six (6) months **and** 3. HgBA1C levels are equal or less than (≤) 10.5% **and** 4. Glomerular filtration rate is greater than or equal to (≥) 45 ml/min/1.73m2 for Invokana **or** ≥ 60ml/min/1.73cm^2 for Farxiga **and** 5. Prior authorizations will be issued at six (6) month intervals if HgBA1C levels are less than or equal to (≤) 8% after treatment. HgBA1C levels submitted must be for the most recent thirty (30) day period.
SGLT2 COMBINATIONS			
		INVOKAMET (canagliflozin/metformin)	
IMMUNE GLOBULINS, IV[CL]			
	BIVIGAM (human immunoglobulin gamma) CARIMUNE NF NANOFILTERED (human immunoglobulin gamma) CYTOGAM (human cytomegalovirus immune globulin) FLEBOGAMMA DIF (human immunoglobulin gamma) GAMASTAN S-D VIAL (human immunoglobulin gamma) GAMMAGARD LIQUID (human immunoglobulin gamma) GAMMAGARD S-D (human immunoglobulin gamma) GAMUNEX-C (human immunoglobulin gamma) GAMMAPLEX (human immunoglobulin	GAMMAKED (human immunoglobulin gamma) HYQVIA (human immuneglobulin g and hyaluronidase) OCTAGAM (human immunoglobulin gamma) PRIVIGEN (human immunoglobulin gamma)	Immune globulin agents will be authorized according to FDA approved indications. A trial of a preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	gamma) HEPAGAM B (hepatitis b immune globulin (human)) HIZENTRA (human immunoglobulin gamma) VARIZIG (varicella zoster immune globulin (human))		
MULTIPLE SCLEROSIS AGENTS[AP]			
	INTERFERONS		A diagnosis of multiple sclerosis and a thirty (30) day trial of a preferred agent in the corresponding class (interferon or non-interferon) will be required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
	AVONEX (interferon beta-1a)[AP] AVONEX PEN (interferon beta-1a)[AP] EXTAVIA KIT (interferon beta-1b)[AP]	BETASERON KIT (interferon beta-1b)[AP] EXTAVIA VIAL (interferon beta-1b)[AP] PLEGRIDY (peginterferon beta-1a)[AP] REBIF (interferon beta-1a)[AP] REBIF REBIDOSE (interferon beta-1a)[AP]	
	NON-INTERFERONS		
	COPAXONE 20 mg (glatiramer)[AP]	AMPYRA (dalfampridine)[CL]* AUBAGIO (teriflunomide)[CL]** COPAXONE 40 mg (glatiramer) GILENYA (fingolimod)[CL]*** TECFIDERA (dimethyl fumarate)[CL]****	
OPHTHALMIC ANTIBIOTIC/STEROID COMBINATIONS[AP]			
	BLEPHAMIDE (prednisolone/sulfacetamide) BLEPHAMIDE S.O.P. (prednisolone/ sulfacetamide) neomycin/polymyxin/dexamethasone sulfacetamide/prednisolone TOBRADEX OINTMENT (tobramycin/ dexamethasone) TOBRADEX SUSPENSION (tobramycin/ dexamethasone)	MAXITROL ointment (neomycin/polymyxin/ dexamethasone) MAXITROL suspension (neomycin/polymyxin/ dexamethasone) neomycin/bacitracin/polymyxin/ hydrocortisone neomycin/polymyxin/hydrocortisone PRED-G (prednisolone/gentamicin) TOBRADEX ST (tobramycin/ dexamethasone) tobramycin/dexamethasone suspension ZYLET (loteprednol/tobramycin)	Three (3) day trials of each of the preferred agents are required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present.
OPIATE DEPENDENCE TREATMENTS			
	BUNAVAIL (buprenorphine/naloxone) SUBOXONE FILM (buprenorphine/naloxone)[CL] VIVITROL (naltrexone) [CL] naloxone	EVZIO (naloxone) SUBOXONE TABLETS (buprenorphine/naloxone) buprenorphine/naloxone tablets ZUBSOLV (buprenorphine/naloxone)	*Buprenorphine/naloxone tablets will only be approved with a documented intolerance of or allergy to Suboxone strips.
PAH AGENTS – PDE5s[CL]			

THERAPEUTIC DRUG CLASS	PREFERRED AGENTS	NON-PREFERRED AGENTS	PA CRITERIA
	sildenafil	ADCIRCA (tadalafil) REVATIO IV (sildenafil) REVATIO SUSPENSION (sildenafil) REVATIO TABLETS (sildenafil)	A thirty (30) day trial of the preferred agent is required before a non-preferred agent will be authorized unless one (1) of the exceptions on the PA form is present. Patients stabilized on non-preferred agents will be grandfathered.